Supreme Court, U.S.
FILED
DEC 27 1995
CLERK

No. 95-821

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

MARY MARTIN, Guardian of Michael Martin,
Petitioner,
v.
PATRICIA MAJOR and LEETA MARTIN,
Respondents.

On Petition for Writ of Certiorari to the Michigan Supreme Court

BRIEF OF THE UNIVERSITY OF MICHIGAN MEDICAL CENTER, WILLIAM BEAUMONT HOSPITAL, HENRY FORD HEALTH SYSTEM AND CHOICE IN DYING, INC., AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

EDWARD B. GOLDMAN
THE UNIVERSITY OF MICHIGAN MEDICAL CENTER
300 N. Ingalls Bldg. N14B18
P. O. Box 0476
Ann Arbor, MI 48109
(313) 764-2178

THOMAS R. MCASKIN
WILLIAM BEAUMONT HOSPITAL
3601 West 13 Mile Road
Royal Oak, MI 48073
(810) 551-0572

JULIE MCCANN-O'CONNOR *
411 Andover Rd. #300 East
Bloomfield Hills, MI 48302
(810) 433-2000
Counsel to William Beaumont Hospital

JOHN R. MUCHA
HENRY FORD HEALTH SYSTEM
1 Ford Place
Detroit, MI 48202
(313) 874-6830

ANNA M. MORETTI
CHOICE IN DYING, INC.
200 Varick Street
New York, NY 10014
(212) 366-5540

Attorneys for Amici Curiae

* Counsel of Record

December 27, 1995

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF THE *AMICI CURIAE*	1
SUMMARY OF ARGUMENT	3
REASONS FOR GRANTING THE WRIT	5
I. THE CERTAINTY REQUIRED BY THE MICHIGAN SUPREME COURT IS MEDICALLY IMPOSSIBLE AND UPSETS THE TRADITIONAL DECISION MAKING FRAMEWORK	6
II. THE MICHIGAN SUPREME COURT'S DECISION ABROGATES THE IMPORTANT ROLE OF SURROGATES	10
III. THE MICHIGAN SUPREME COURT'S OPINION HAS A DELETERIOUS EFFECT ON MEDICAL DECISION MAKING	13
CONCLUSION	14

TABLE OF AUTHORITIES

CASES: Page

Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990) 10
Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988) 14
In re Conroy, 486 A.2d 1209 (N.J. 1985) 13, 14
Thompson v. Oklahoma, 487 U.S. 815 (1988) 11

STATUTES AND OTHER AUTHORITIES:

Omnibus Budget Reconcilitation Act of 1990, Pub. L. 101-508, §§ 4206, 4751, 42 U.S.C. § 1395 *et seq.* (1993 & Supp. 1995) 12, 13
Mich. Comp. Laws Ann. § 700.496(7)(d) (West 1992) 12
Nancy Neveloff Dubler, *Commentary: Balancing Life and Death—Proceed with Caution*, 83 Am. J. Pub. Health 23 (1993) 9
Leon Jaroff, *Knowing When to Stop: Doctors Go to Heroic Lengths to Keep Terminally Ill Patients Alive—Often Against Their Wishes*, Time, Dec. 4, 1995 9
Bernard Lo, Editorial, *Improving Care Near the End of Life: Why Is It So Hard?*, 274 JAMA 1634 (1995) 9
Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. Pub. Health 14 (1993) 9
The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995) 9
Bruce C. Vladeck, *Editorial: Beliefs vs Behaviors in Healthcare Decision Making*, 83 Am. J. Pub. Health 13 (1993) 9

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

No. 95-821

MARY MARTIN, Guardian of Michael Martin,
Petitioner,

v.

PATRICIA MAJOR and LEETA MARTIN,
Respondents.

On Petition for Writ of Certiorari to the Michigan Supreme Court

---

BRIEF OF THE UNIVERSITY OF MICHIGAN MEDICAL CENTER, WILLIAM BEAUMONT HOSPITAL, HENRY FORD HEALTH SYSTEM AND CHOICE IN DYING, INC., AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

INTEREST OF THE *AMICI CURIAE*

The University of Michigan Medical Center (the "Center"), located in Ann Arbor, Michigan, is an 880 bed facility with 156 intensive care unit beds. The Center provides intensive care to a substantial number of nursing home, elderly, and acutely-ill individuals. It has an active ethics committee and has been intimately involved with life-support issues for the past 20 years.

William Beaumont Hospital (the "Hospital"), located in Royal Oak, Michigan, operates two hospitals compris-

ing 1,118 beds in Oakland County, Michigan. The Royal Oak facility is a tertiary care center. The Troy facility is a community hospital. The Hospital operates outpatient clinics, and has residency programs for training physicians. Through its nursing home subsidiaries, the Hospital has 834 assisted living and skilled nursing home beds. End-of-life decisions are addressed by the multidisciplinary Ethics Education and Patient Rights committees.

Henry Ford Health System (the "System") is a regional, vertically integrated health care delivery system located in the Metropolitan Detroit area. It consists of 6 hospitals, 2 nursing homes, a chemical dependency facility and 35 ambulatory care clinics. The System includes a closed group practice of over 1,000 physicians, a teaching program with over 700 house officers and a health maintenance organization of over 450,000 members. Through its Ethics Committee, the System frequently deals with termination of life-sustaining treatment issues.

Choice In Dying, Inc. ("Choice In Dying") is a national, not-for-profit organization dedicated to addressing the legal, ethical and social issues involved in end-of-life decision making, as well as ensuring the proper care of dying patients. The organization was formed in 1991 by the merger of the Concern for Dying and the Society for the Right to Die.

Because Choice In Dying is considered a national expert on issues surrounding the right to die, it and its predecessor organizations have filed briefs as *amicus curiae* in most of the major right-to-die cases decided in recent years, including: *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Busalacchi*, No. 73677, 1993 WL 288532 (Mo. Jan. 26, 1993) (*en banc*); *DeGrella v. Elston*, 858 S.W.2d 698 (Ky. 1993); *In re Guardianship of Jane Doe*, 583 N.E.2d 1263 (Mass.), *cert. denied sub nom. Doe v. Gross*, 503 U.S. 950 (1992); *McConnell v. Beverly Enters.-Connecticut, Inc.*, 553 A.2d 596 (Conn. 1989); *In re Drabick*, 245

Cal. Rptr. 840 (Ct. App.), *cert. denied,* 188 U.S. 1024 (1988); and *In re Jobes,* 529 A.2d 434 (N.J. 1987). In addition, Choice In Dying regularly provides information on legislation, regulation and judicial action to the general public, the practicing bar, health care providers, the clergy and others concerned with the legislative and judicial processes. The organization has a membership of approximately 65,000 nationwide, nearly 1,600 of whom reside in Michigan.[1]

SUMMARY OF ARGUMENT

1. The Michigan Supreme Court's determination that a state need not honor an individual's prior expressed wishes concerning his treatment unless the individual predicted the "specific circumstances" under which he would lose capacity makes no sense from a medical perspective. There are a wide array of closely related medical conditions in which a patient may lose permanently the capacity to make medical decisions. Thus, it is impossible for an individual, even one who is medically sophisticated, to predict with certainty the "specific circumstances" which will lead to the loss of capacity.

For precisely this reason, states such as Michigan have adopted formal mechanisms which allow individuals to appoint surrogates for medical decision making. Surrogates can, and are specifically empowered to, address unanticipated problems which arise in circumstances the patient was unable specifically to foresee.

By allowing patients' wishes to be honored only in those circumstances which the patient has specifically predicted, the Michigan Supreme Court has taken away the direct means by which patients can control their own care. And by precluding surrogates from acting except where pa-

---

[1] Pursuant to Rule 37.3(a) of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

tients have specifically predicted their condition, that court has also taken away the indirect mechanism by which patients can control their care. By closing off both of these avenues, that court has impermissibly burdened the liberty interest of patients to control their own medical care.

In taking these actions, the Michigan Supreme Court also has radically interfered with the means by which decisions about termination of treatment currently are made. Such decisions typically are made (and traditionally have been made) by physicians, acting on the basis of whatever wishes the patient has expressed, and in consultation with the patient's family. And, to assist in and to ensure the propriety of such decisions, most states, including Michigan, have established formal mechanisms by which patients can express their wishes, and most hospitals have established ethics committees to help resolve difficult issues.

Under the regime established by the decision below, however, physicians will be unable, except in rare instances, to determine whether to withdraw life-prolonging treatment on the basis of their knowledge of a patient's wishes and conversations with a patient's family. Instead, they will be forced to seek court approval of their actions. That additional step will unnecessarily interfere with physicians' relationships with their patients.

That interference is not an abstract concern. Empirical studies demonstrate that a significant mismatch currently exists between the amount of terminal care that patients want and the amount of care they receive. That mismatch exists, in large measure, because of uncertainty among providers about the circumstances under which they legally can withhold or withdraw treatment, and it can only be exacerbated by court decisions, such as the Michigan Supreme Court's, which make it more difficult for physicians to follow patients' wishes concerning termination of treatment, whether expressed directly by patients or by their surrogates.

2. This Court should not permit state courts, such as the Michigan Supreme Court, drastically to restrict the circumstances under which a duly appointed surrogate may act. Few individuals provide explicit instructions regarding their wishes in the event they lose the capacity to make medical decisions for themselves. Thus, as a practical matter, health care providers must rely on surrogates to ensure that they abide by a patient's general wishes and values. Unless this Court makes clear that surrogates play an important role in protecting and advancing patients' liberty interests, the efforts of many state legislatures (including Michigan's), as well as the efforts of many hospitals, to promote surrogate decision making will be thwarted.

3. Finally, the Michigan Supreme Court's decision, if allowed to stand, will have a deleterious effect on decisions made by patients in that state. Without reasonable assurances that their wishes concerning termination of treatment will be honored, many patients will elect simply to forgo certain interventions, even those which have some chance of providing great benefit. As a result, patients may pass up treatments which, from a purely medical perspective, they should try.

REASONS FOR GRANTING THE WRIT

While the *Martin* majority attempts to limit the scope of its holding to the narrow facts present, the opinion is inconsistent and its effect extends beyond just patients in Michael Martin's precise condition and surrogates attempting to effect those patients' wishes. The decision leaves health care providers in a state of turmoil: the "clear and convincing" evidentiary standard, as formulated and applied by the Michigan Supreme Court, is for all practical purposes impossible for hospitals and physicians to satisfy; the health care providers' traditional relationship with the patient and family members has been significantly infringed; the reliance which health care pro-

viders, in recent years, have come to place upon a patient's advance directive, surrogate or guardian, has been rendered highly questionable; and the nature of the proof required by the court will likely mean that medical treatment decisions will be made which do not conform to the wishes of the patient or are not beneficial to the patient.

I. THE CERTAINTY REQUIRED BY THE MICHIGAN SUPREME COURT IS MEDICALLY IMPOSSIBLE AND UPSETS THE TRADITIONAL DECISION MAKING FRAMEWORK

Throughout his entire adult life, Michael Martin was adamant in his opposition to artificial life-support in the event catastrophic illness or injury rendered him helpless and hopeless. Like so many other patients, Michael could not possibly have foreseen and described the specific injuries which he would suffer in his accident. In fact, it is medically impossible to predict one's future medical condition with the certainty the Michigan Supreme Court required of Michael. There are an enormous variety of closely related medical syndromes in which a patient loses capacity and becomes dependent: in some of these conditions, the patient may be conscious; in others, unconscious; and in still others, it may be unclear. Because of this practical problem, the Michigan Legislature, like many other state legislatures and ethicists nationwide, has recognized that the best way for a patient to maintain control over future medical treatment is to appoint a surrogate to make decisions for the patient when the patient has lost capacity.

For the Michigan Supreme Court to require absolute prescience as to the precise nature of future medical conditions virtually guarantees that individuals who do not want to be maintained in a dependent state, regardless of their underlying illness or mental state, will be unable to exercise their right to refuse treatment. By holding that a patient's wishes can be effectuated only where the pa-

tient has accurately predicted his precise condition, the Michigan Supreme Court has taken away the patient's direct mechanism for controlling his care. Then, by holding that a surrogate can only act where the patient has predicted his condition with absolute certainty, the court has also taken away the patient's only means to deal with that inherent uncertainty. In so doing, the court has impermissibly burdened a patient's primary and secondary means to effectuate his right to control his medical care and because of the medical reality of such uncertainty, has effectively left patients with no rights at all.

The practical reality is that health care providers frequently make withdrawal of treatment decisions based upon the incompetent patient's condition and prognosis, discussions with family members to ascertain the patient's previously-expressed wishes, values and life-style,[2] and consideration by a hospital ethics committee of the propriety of the proposed withdrawal of treatment. In fact, all of this occurred before Mary Martin petitioned the Probate Court to permit her to withdraw her husband's medical treatment.[3]

The *amici* fear that the decision below means that health care providers must turn to the courts whenever

---

[2] The *Martin* majority concedes that its opinion runs counter to those from other jurisdictions which have almost unanimously granted the request of patients or guardians based upon evidence of the patient's wishes, values and life-style. See Petition for Writ of Certiorari, App. 18a-19a. The decision below almost totally disregarded all of those factors.

[3] As noted by Justice Levin in his dissent, the majority of the Michigan Supreme Court is "the first disinterested body to examine Michael Martin's case without being convinced by the ample evidence of his prior wishes." Petition for Writ of Certiorari, App. 31a. The Bioethics Committee of Butterworth Hospital concluded that the termination of Michael's medical treatment was both ethical and consistent with his pre-injury wishes. The independent guardian ad litem also recommended that life-support be withdrawn. The Probate Court and Michigan Court of Appeals reached the same conclusion.

termination of life-sustaining medical treatment is being considered and that, for conscious but incompetent patients, treatment will always need to be provided. Any common sense review of Michael Martin's statements regarding medical treatment would lead most providers to conclude that he never wanted to be maintained artificially in the dependent state in which he persists. The Michigan Supreme Court's opinion, holding that clear and convincing evidence of Michael's decision was not proved, leads to the obvious question, "How is the clear and convincing evidence standard to be translated at the bedside?" The *amici* fear that, as a result of the decision below, end-of-life decision making will be removed from the bedside and legal intervention will be routinely required. This will cause a serious breakdown in the doctor-patient relationship and will dramatically affect the manner in which decisions involving life-sustaining treatment are made.

In requiring absolute certainty before effectuating patients' wishes, the Michigan Supreme Court has radically interfered with the traditional framework in which end-of-life decisions are made. Traditionally, doctors have made these decisions together with patients and their families. To protect patients, many states, including Michigan, have put in place mechanisms to formalize that process, providing opportunities for patients to state their wishes and designate surrogates should they lose capacity to make these decisions for themselves. Hospitals have established bodies such as ethics committees to help doctors and patients in these situations.

The Michigan Supreme Court's decision destroys that process. Because of the standard of certainty it requires, doctors can no longer be confident that they are acting in accordance with their patients' wishes and cannot turn to surrogates for assistance. Doctors frequently will be forced to turn to the courts. This will not only prolong an already anguished period for patients and their families,

but it will make medical decision making tremendously more burdensome and expensive.

The Michigan Supreme Court's decision also further complicates the ability of health care providers to act in accordance with their patients' wishes. As a result of that court's decision, health care providers do not know where to turn to determine their patients' wishes or whether they can act to effectuate their patients' desires. This confusion increases the problems already existing in end-of-life decision making for health care providers. Currently, a tragic mismatch exists between the excessive amount of terminal care actually provided to patients and the amount of terminal care these patients truly desire. *See* The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995). *See also* Bernard Lo, Editorial, *Improving Care Near the End of Life: Why Is It So Hard?*, 274 JAMA 1634 (1995); Leon Jaroff, *Knowing When to Stop: Doctors Go to Heroic Lengths to Keep Terminally Ill Patients Alive—Often Against Their Wishes*, Time, Dec. 4, 1995, at 76. This mismatch is tied, in large measure, to health care professionals' uncertainty over liability for acting on patients' desires to terminate life-sustaining treatment. *See* Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. Pub. Health 14, 19-20 (1993). *See also* Nancy Neveloff Dubler, *Commentary: Balancing Life and Death—Proceed with Caution*, 83 Am. J. Pub. Health 23, 24-25 (1993); Bruce C. Vladeck, *Editorial: Beliefs vs Behaviors in Healthcare Decision Making*, 83 Am. J. Pub. Health 13, 13 (1993). By disregarding most factors health care professionals consider when making these decisions with patients and their families, the Michigan Supreme Court has created further uncertainty which will force providers to turn to the courts, even in cases where a consensus may exist among those concerned for the

patient. This will serve only to exacerbate the dissatisfaction of patients and their families and will effectively prevent providers from correcting this problem.

In sum, the Michigan Supreme Court's decision fails to recognize the inherent uncertainties of medical decision making which make it impossible for patients to predict the specific circumstances which will befall them. As a result, that court has made it virtually impossible for patients to have their wishes effectuated, even when the health care provider and the patient's family are quite certain that termination of treatment is what the patient would have wanted. The court has also turned medical decision making on its head by radically interfering with the traditional framework in which decisions about termination of treatment are made; by further confusing an already uncertain area; and by placing courts, and not patients, those who are concerned for them, or health care providers, in the role of medical treatment decision maker.

II. THE MICHIGAN SUPREME COURT'S DECISION ABROGATES THE IMPORTANT ROLE OF SURROGATES

The decision below shows how the clear and convincing standard of proof can be manipulated to deny a person's liberty interest, and it starkly underscores why surrogates are so important. Because none of us has the ability to foresee precisely what will happen to us in the future, it is sometimes only through a trusted surrogate that our desires and values can be effectuated, and our liberty interest protected. As Justice O'Connor noted in *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990), "[f]ew individuals provide explicit oral or written instructions regarding their intent to refuse medical treatment should they become incompetent." [4] As a practical matter, it is essential for health care providers to consult with an incompetent patient's surrogate in order to ensure that the patient's wishes and values are taken into account.

---

[4] *Id.* at 289 (O'Connor, J., concurring).

Given the inability of individuals to predict with specificity what particular illnesses or injuries might arise in the future, the utilization of a surrogate is essential to ensure that an incompetent patient's liberty interests are protected. *See, e.g., Thompson v. Oklahoma*, 487 U.S. 815 (1988) (plurality opinion). *Thompson* involved a minor who was convicted of first degree murder and sentenced to death. The issue presented was whether execution of the sentence would violate the constitutional prohibition against cruel and unusual punishment because the petitioner was only 15 years old at the time of the offense. The Court recognized that "[t]he law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise choice freely and rationally," noting that "those who are irreversibly ill with loss of brain function . . . retain 'rights,' to be sure, but often such rights are only meaningful as they are exercised by agents acting with the best interests of their principals in mind." *Thompson*, 487 U.S. at 825 n.23 (citing John H. Garvey, *Freedom and Choice in Constitutional Law*, 94 Harv. L. Rev. 1756 (1981)).

The *amici* urge this Court to decide not only the issue of whether the States must defer to a surrogate's decisions when the patient has expressed the desire to have the surrogate act for him, but also to what extent the "clear and convincing" standard of proof can be used to limit the surrogate's authority. A fair reading of *Martin* compels the conclusion that, absent a specific description of the medical condition for which a withdrawal-of-treatment decision is to be made by a surrogate, the Michigan Supreme Court would not permit the surrogate to act. According to the court:

> A proper designation allows a third person to execute the patient's treatment decisions, even if the decision will result in death, *provided the patient is in the condition delineated in the patient advocate designation.*[5]

[5] Petition for Writ of Certiorari, App. 13a (emphasis added).

However, that is not what Michigan's medical proxy statute requires or contemplates, and the court should not have extended its restrictive interpretation of the "clear and convincing" evidentiary standard in such a manner. The Michigan statute uses the "clear and convincing" standard in two contexts only: a patient can authorize his advocate to make withdrawal of treatment decisions which result in death "only if the patient has expressed in a clear and convincing manner that the patient advocate is *authorized* to make such a decision," and the patient must *acknowledge* in a clear and convincing manner that "such a decision could or would allow the patient's death."[6] The statute, like many throughout the nation, nowhere requires a specific description of the patient's condition before the advocate has a right to make certain treatment decisions. This is consistent with the notion that, once a patient designates an advocate, the advocate may make all medical treatment decisions for the patient, including those that might result in the patient's death.

Following enactment of the Michigan statute, most hospitals throughout Michigan have utilized a medical durable power of attorney form adopted by the Michigan Hospital Association, the Michigan State Medical Society, the Michigan Association of Osteopathic Physicians & Surgeons, Inc., and the State Bar of Michigan. This form is made available to patients as part of the hospitals' obligation, under the Federal Patient Self-Determination Act, to advise patients of their right to designate a surrogate to make decisions regarding life-sustaining medical treatment.[7] Yet *Martin* raises a serious question as to the

---

[6] Mich. Comp. Laws Ann. § 700.496(7)(d) (West 1992) (emphasis added).

[7] Omnibus Budget Reconciliation Act of 1990 (OBRA-90), Pub. L. 101-508, §§ 4206 and 4751 (Medicare and Medicaid, respectively), 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395cc(i), 1395mm(c)(8), 1396a(a)(57), 1396a(a)(58), and 1396a(w) (1993 & Supp. 1995). The Act requires that health care providers maintain written policies and procedures with respect to all individuals receiving medical

validity of the form, inasmuch as it does not require that the patient describe with specificity the circumstances under which a surrogate may withdraw life-sustaining medical treatment.

III. THE MICHIGAN SUPREME COURT'S OPINION HAS A DELETERIOUS EFFECT ON MEDICAL DECISION MAKING

The decision below will only serve to exacerbate problems which health care providers experience insofar as termination of life-sustaining treatment is concerned. Rather than risk being denied the right to remove a gastrostomy tube, many patients and their families may decide simply to forgo insertion of the tube and run the "risk" of poor nutrition and hydration. This can often be medically counterproductive because such a tube may be the extra therapeutic support needed by the patient to pull through a limited medical crisis. This negative impact on medical decisions has been recognized by the courts. *See In re Conroy*, 486 A.2d 1209 (N.J. 1985). The court in that case was presented with the request of a guardian to remove a nasogastric tube on behalf of a comatose patient who had not previously expressed any sentiment on life-support. The court noted:

> Moreover, from a policy standpoint, it might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could permissibly be withheld. Such a rule could discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die.

---

care by or through the provider, to advise their patients of the right, under state law, to make decisions concerning medical care, "including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives." 42 U.S.C. 1395cc(f)(1)(A).

In re Conroy, 46 A.2d at 1234. *See also Gray v. Romeo*, 697 F. Supp. 580, 588-89 & n.4 (D.R.I. 1988) (authorizing husband/guardian of unconscious patient to remove feeding tube and life-support of spouse). The *Martin* holding will only serve to chill full and frank discussions between patients, their families, and their physicians, and create doubt in the minds of the decision makers at a time when they do not have days or weeks to reflect on their decision.

CONCLUSION

As a result of the significant negative impact which the decision below has had on the medical community and on the ability of patients and their surrogates to be involved in the medical decision making process, the *amici* urge that the petition for a writ of certiorari be granted.

Respectfully submitted,

EDWARD B. GOLDMAN
THE UNIVERSITY OF MICHIGAN
MEDICAL CENTER
300 N. Ingalls Bldg. N14B18
P. O. Box 0476
Ann Arbor, MI 48109
(313) 764-2178

THOMAS R. MCASKIN
WILLIAM BEAUMONT HOSPITAL
3601 West 13 Mile Road
Royal Oak, MI 48073
(810) 551-0572

JULIE MCCANN-O'CONNOR *
411 Andover Rd. #300 East
Bloomfield Hills, MI 48302
(810) 433-2000
Counsel to William Beaumont Hospital

JOHN R. MUCHA
HENRY FORD HEALTH SYSTEM
1 Ford Place
Detroit, MI 48202
(313) 874-6830

ANNA M. MORETTI
CHOICE IN DYING, INC.
200 Varick Street
New York, NY 10014
(212) 366-5540

Attorneys for Amici Curiae

December 27, 1995

* Counsel of Record